United States Department of Labor
Employees' Compensation Appeals Board

R.G., Appellant	)	
and	)	**Docket No. 13-220**
	)	**Issued: May 9, 2013**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Denver, CO, Employer	)	

Appearances:
John Eiler Goodman, Esq., for the appellant
No appearance, for the Director

Oral Argument April 2, 2013

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 7, 2012 appellant, through her attorney, filed a timely appeal from a September 28, 2012 decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the decision.

ISSUE

The issue is whether appellant established that she has more than nine percent impairment of the right upper extremity for which she received a schedule award.

On appeal, appellant's attorney asserts that all conditions, including those preexisting and subsequently acquired, should be included in a schedule award determination. He indicated that the statement of accepted facts was incomplete and further contended that OWCP erred in ruling that only carpal tunnel syndrome could be considered in granting a schedule award when the

[1] 5 U.S.C. §§ 8101-8193.

residuals of ganglion cyst and ulnar nerve surgery should be considered. Counsel requested that appellant be referred for a second opinion evaluation.

FACTUAL HISTORY

This case has previously been before the Board. In a December 1, 2005 decision, the Board found that OWCP properly determined in an August 20, 2004 decision that appellant's diagnosed condition of thoracic outlet syndrome required further medical development and therefore properly denied acceptance of the condition at that time.[2] The facts of the previous Board decision are incorporated herein by reference.

In January 2005 OWCP referred appellant to Dr. John D. Douthit, a Board-certified orthopedic surgeon, for a second opinion evaluation. In reports dated February 16, May 2 and 24, 2005, Dr. Douthit advised that electrodiagnostic studies did not support a diagnosis of thoracic outlet syndrome. He diagnosed employment-related mild carpal tunnel syndrome and a complex pain syndrome of the neck and upper extremities that was not employment related. Appellant stopped work with the Federal Government on February 18, 2005 and retired on disability, effective May 14, 2005. She underwent carpal tunnel release surgeries on the right and left on July 12, 2006 and January 3, 2007 respectively. On June 27, 2007 appellant underwent right shoulder surgery.

In correspondence dated February 24, 2010, appellant requested a schedule award. She submitted a December 24, 2009 report from Dr. L. Barton Goldman, a Board-certified physiatrist, who completed The Disabilities of the Arm, Shoulder and Hand Score (*Quick*DASH) and activities of daily living questionnaires, and provided range of motion findings of bilateral elbows and shoulder. Dr. Goldman advised that he evaluated appellant's upper extremities in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[3] Regarding the right upper extremity, appellant's right shoulder myofascial pain condition yielded an eight percent impairment; she had three entrapment neuropathies on the right that yielded an additional six percent impairment; and her brachial plexus condition yielded a four percent arm impairment. Dr. Goldman utilized the Combined Values Chart to total 17 percent impairment of the right upper extremity, based on appellant's diagnosis-based impairment for the shoulder and peripheral nerve impairments for brachial plexus, lower trunk and carpal tunnel syndrome. Regarding the left upper extremity, her left shoulder myofascial pain yielded an 8 percent impairment and her left carpal tunnel syndrome yielded a 3 percent arm impairment or a total 11 percent left upper extremity impairment.[4]

On September 25, 2012 OWCP asked its medical adviser, Dr. Morley Slutsky, Board-certified in occupational medicine, to provide a report regarding appellant's bilateral upper extremity impairments. In the transmittal memorandum, it noted that bilateral carpal tunnel

[2] Docket No. 05-906 (issued December 1, 2005).

[3] A.M.A., *Guides* (6th ed. 2008).

[4] Dr. Goldman previously submitted an impairment rating dated September 23, 2008 in which he evaluated appellant's impairment under the fifth edition of the A.M.A., *Guides*.

syndrome was accepted that right medial and lateral epicondylitis, right shoulder adhesive capsulitis, and aggravation of displacement of cervical disc without myelopathy were nonexistent, nonwork related or resolved, according to the second opinion evaluation of Dr. Douthit. The medical adviser was instructed to review the record, including the statement of accepted facts and provide an impairment evaluation.

In a September 26, 2012 report, Dr. Slutsky reviewed the medical evidence including Dr. Goldman's reports and electrodiagnostic studies. He stated that Dr. Goldman incorrectly rated three neuropathies in the right arm when it was only appropriate to review compression neuropathy under Table 15-23 of the A.M.A., *Guides*. Due to carpal tunnel syndrome, appellant had a nine percent right upper extremity impairment and a zero percent (no) impairment on the left. He noted that right shoulder adhesive capsulitis was not a listed diagnosis, and there was no objective evidence that bilateral medial or lateral epicondylitis were present.

By decision dated September 28, 2012, appellant was granted a schedule award for a nine percent impairment of the right upper extremity.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing federal regulations[5] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7] For decisions issued after May 1, 2009, the sixth edition will be used.[8]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[9] Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and

[5] 20 C.F.R. § 10.404.

[6] *Id*. at § 10.404(a).

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[8] FECA Bulletin No. 09-03 (issued March 15, 2009).

[9] A.M.A., *Guides*, *supra* note 3 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[12] In Table 15-23, grade modifiers levels (ranging from zero to four) are described for the categories test findings, history and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[13]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[14]

ANALYSIS

The Board finds that this case is not in posture for decision. The record reveals that medial and lateral epicondylitis, right; adhesive capsulitis, right shoulder; temporary aggravation of displacement of cervical disc without myelopathy; temporary aggravation of displacement of lumbar disc without myelopathy; and bilateral carpal tunnel syndrome are accepted conditions. The Board, however, notes that the record is inconsistent as to whether a right ganglion has been accepted as employment related. Neither the January 3, 2005 statement of accepted facts nor the statement of accepted facts addendum dated September 20, 2012 include it as an accepted condition. However, in a January 6, 2009 letter to appellant, OWCP indicated that a ganglion on the right was an accepted condition.

Regarding the assertion on appeal that both preexisting and subsequently acquired conditions are to be included in a schedule award determination, it is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[15] There is no basis for including subsequently acquired conditions. OWCP procedures provide:

> "Impairment ratings for schedule awards include those conditions accepted by the OWCP as job-related and any preexisting permanent impairment of the same

[10] *Id*. at 385-419.

[11] *Id*. at 411.

[12] *Id*. at 449.

[13] *Id*. at 448-50.

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[15] *Peter C. Belkind*, 56 ECAB 580 (2005); *Raymond E. Gwynn*, 35 ECAB 247 (1983).

> member or function. If the work-related injury has affected any residual usefulness in whole or in part, a schedule award may be appropriate. There are no provisions for apportionment under the FECA. Rated impairment should reflect the total loss as evaluated for the schedule member at the time of the rating exam[ination]."[16]

In his December 24, 2009 report, Dr. Goldman did not clearly identify the tables he utilized in his impairment analysis. The sixth edition of the A.M.A., *Guides* requires that, after identifying the impairment class for the diagnosed condition, this is then adjusted by grade modifiers based on functional history, physical examination and clinical studies,[17] to be followed by application of the net adjustment formula.[18] Dr. Goldman did not provide sufficient explanation of the diagnosis categories, class or evaluation of the grade modifiers he applied to rate impairment. As discussed, grade modifiers should be considered for functional history, physical examination and clinical studies and these grade modifiers can change the extent of a given impairment rating. Moreover, Dr. Goldman provided a rating for shoulder myofascial pain. This is not an accepted condition. The Board notes that Dr. Goldman's physical findings, on which the September 28, 2012 schedule award was based, are more than three years old.

The Board also finds the report of Dr. Slutsky is insufficient to establish the extent of permanent impairment. Dr. Slutsky relied on a transmittal memorandum that included an equivocal statement regarding what conditions were accepted. It is also unclear whether he reviewed the case file to determine if appellant would be entitled to an schedule award for preexisting upper extremity conditions.

Where impairment has not been correctly described, a new or supplementary evaluation should be obtained.[19] As the medical evidence of record does not fully comport with the A.M.A., *Guides* or provides a complete analysis of appellant's right upper extremity impairment, the Board finds that the case is not in posture for decision. The case is remanded to OWCP for further development of the medical evidence on the extent of impairment of appellant's right upper extremity in accordance with the sixth edition of the A.M.A., *Guides*. On remand, OWCP should prepare an updated statement of accepted facts that includes all accepted conditions and refer appellant to an appropriate physician for a second opinion evaluation. Following such further development as OWCP deems necessary, it should issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision as to the extent of appellant's right upper extremity impairment.

[16] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.806.5(d) (February 2013).

[17] *Supra* note 10.

[18] *Supra* note 11.

[19] *L.H.*, 58 ECAB 561 (2007).

ORDER

IT IS HEREBY ORDERED THAT the September 28, 2012 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for proceedings consistent with this decision of the Board.

Issued: May 9, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board